QTool Clinical Support Tool — Quick Tips

Alabama Medicaid Agency
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URL

www.qtool.alabama.gov

QTool melds disparate sources of patient data, overlays the information with clinical alerts and presents the data to the provider as a single patient record.

TIPS AND SETUP

Tips

- Load all morning patients first thing in the morning
- Load all afternoon patients before leaving for lunch
- If doctors, nurses, or other personnel from your location are not displaying in the Provider drop down lists for adding records, this is because these staff members are not added to your location's list of possible providers and clinicians. Please contact your Business Administrator to add the person as a staff member of your location.
- **Business Administrators—** Don't forget to click all possible locations for the provider or staff member for each location they could practice at.

Set Up

XP Operating System
To ensure Selection Boxes are displaying

- Right mouse click on the your desktop. Menu appears.
- Select Properties from the menu Display Properties window appears.
- Select Windows and buttons Tab.
- From dropdown box. select Windows XP Style.
- Click OK to save the change.

BUTTON AND ICON GUIDE


Add Record


Edit Record or portion of record


Delete Record


Save Record or Change


Save Record or Change


Search to Find Patient, procedure, lab etc.


Cancel. Clears current edits and returns the user to last page


Personal History—Adding Substance—Delete Button


Restores the screen to the original display.

Expand—Shows all the detail for a date of service, diagnosis code, procedure code etc.
Collapse—Hides the details of the dates of service/results and shows only a summary of data

SECURITY

To retain the integrity and privacy of patient data, the following roles are allowed to add, edit, and delete data that was provider-entered. Some clinical records (Vitals, Allergies, Lab) have limited edit ability or history of changes enabled.

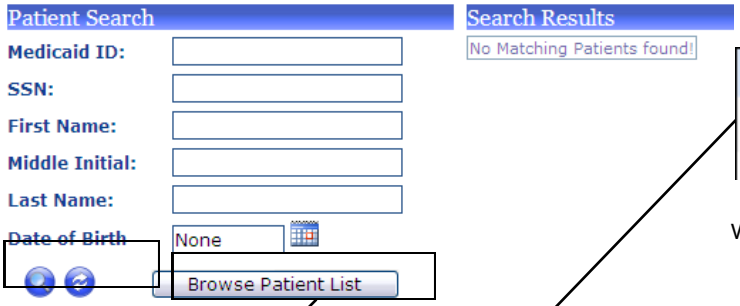
- Prescribers
- Business Administrators
- Clinical Users

DATA SOURCES

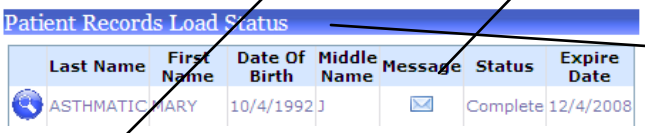
EDS = Alabama Medicaid data;
BCBS = BCBS of Alabama data
Provider Entered = Added to the system through the application by an authorized provider

PATIENT SEARCH

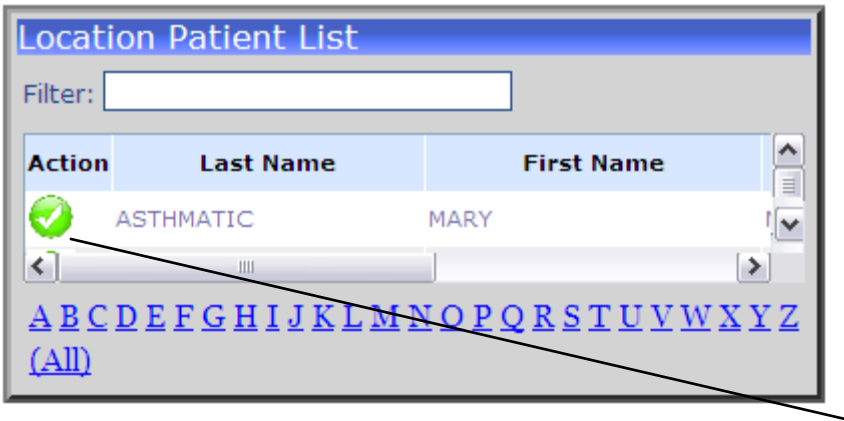
Enter in patient's information then press the Magnifying Glass to commence search .



Click on the envelope to display status messages that occurred while gathering the patient's information from the various data sources.



A patient record remains in this list for 4 hours and then is deleted. You may find the patient's name in the Location



- Click Browse Patient List on this button to display the list of patients your location has searched for.
- When the screen appears, you may still select a patient to load the data and have it appear in Patient Record Load Status.
- Click Hide Patient List to close the Location Patient List. The button changes to Browse Patient List
- The Patient records stay in the Location Patient List for 90 days. The counter is reset each time the patient record is loaded.

If patient <u>does not</u> appear in the <u>Location Patient List</u>

✓ In the <u>Patient Search</u> section enter in a valid search

- Medicaid ID only (first 12 digits); **OR**
- SSN only; **OR**
- First & Last Name (initial is optional) & DOB

✓ Left-click on this icon in the <u>Patient Search</u> section to start the search.

✓If Patient found, name appears in <u>Patient Search Results</u> screen.

✓If Patient is not found, you may add the patient. Refer to Page 5.

NOTE: If patient's name changed, the Search results will display the new name even if you searched with the "old" name.

✓ Left mouse-click on on patient's name in the Patient Search Results screen.

✓ The system is gathering the patient's information. Once it is finished, the selected patient's name will display in the <u>Patient Records Load Status</u> window with the Load status.

✓ **You may select as many names as desired. You do not need to wait for each patient to load to select a new patient.**

If patient <u>appears</u> in the <u>Location Patient List</u>

✓ In the Location Patient List window, select the patient's name by moving the mouse pointer and clicking on the icon.

✓ The selected patient's name will display in the <u>Patient Records Load Status</u> window with the appropriate status.

✓ **You may select as many names as desired. You do not need to wait for each patient to load to load a new patient information.**

PATIENT SUMMARY

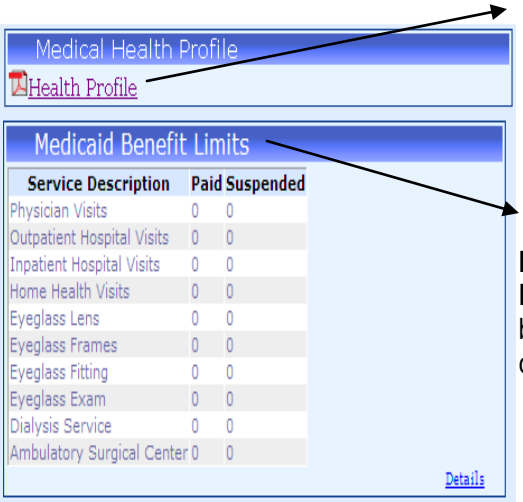
Provides a concise and comprehensive view of the patient's information. Each section on the Patient Summary page has it's associated details page. Use the menu or page or the Details if it is Blue at the bottom of the section to display the page.

Alerts: displays all Allergy, Clinical and Drug alerts.

Details hyperlink displays the Date of Service that triggered the alert and a brief Alert description.

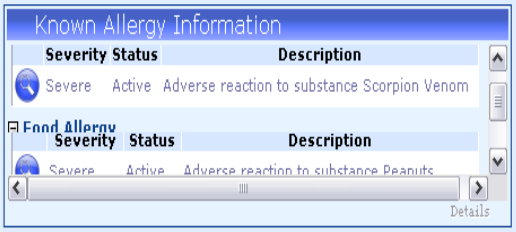
Message hyperlink displays a brief description of the alert.

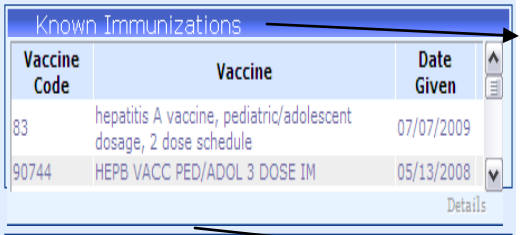
Health Profile: create and print the Patient's Health profile, such as vitals, procedures, etc.



Medicaid Benefits Limits: displays benefit limits for the current year.

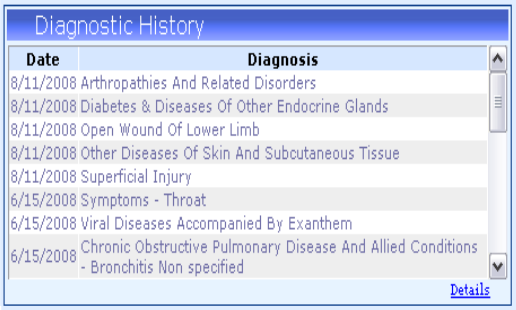
Allergy: display all allergies the provider entered for the patient.





Immunization: lists the last 5 immunizations found in claims or provider entered.

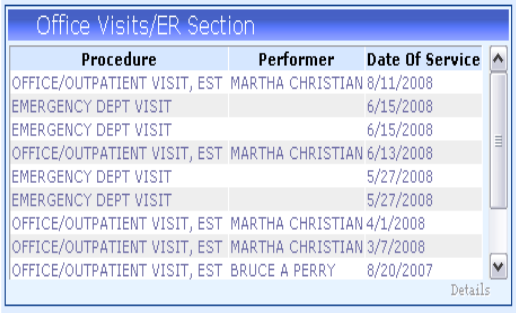
Diagnostic History: lists up to the last 30 unique diagnosis codes from claims and provider entered grouped by diagnosis code.

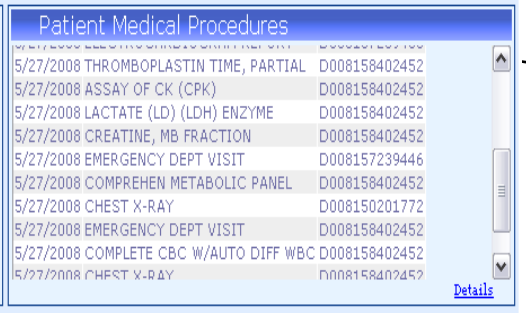


Prescriptions: lists the last 100 days from the current date of prescriptions from claims and e-prescribed.

Office Visits/ER:

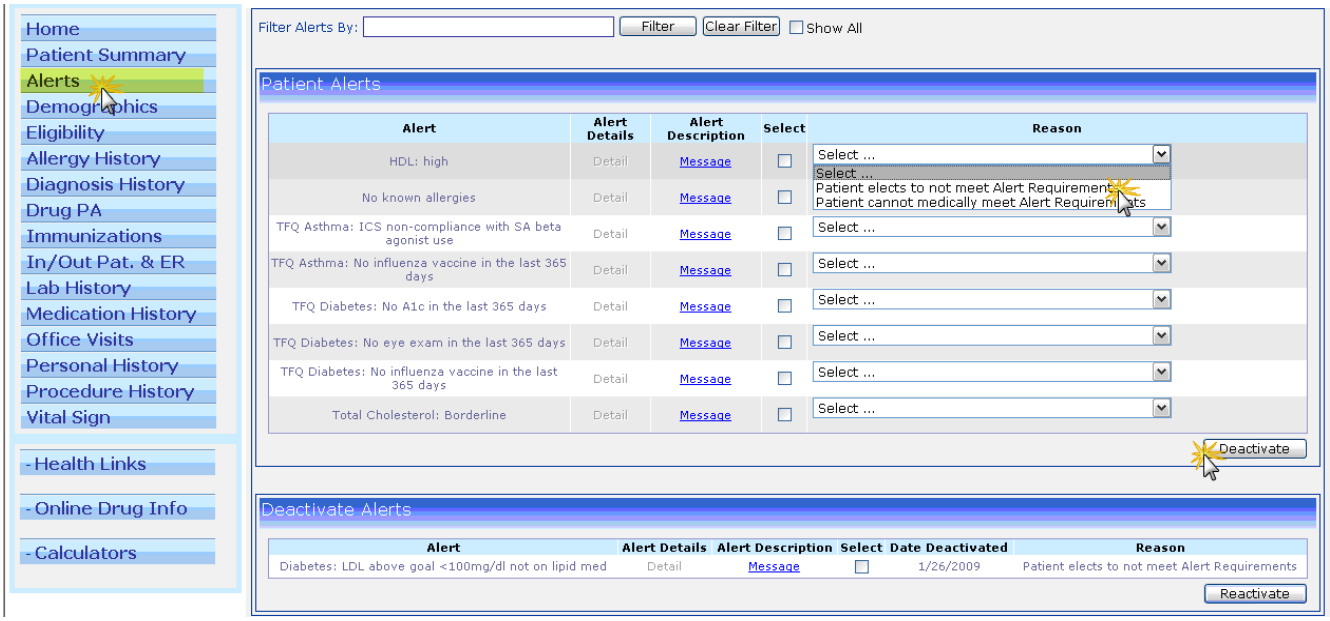
- Displays the last 10 ER visits.
- Displays the last 12 office visits.





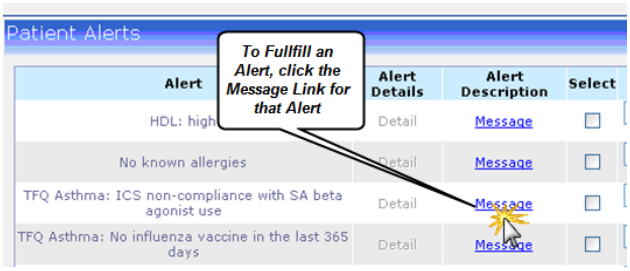
Procedures: lists up to the last 30 unique procedure codes from claims and provider entered.

ALERT DEACTIVATION AND FULFILLMENT

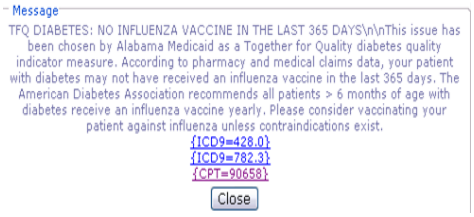


- **Alert Deactivation (Patient will not or Cannot Comply)**
  - **<u>Alert Deactivation is only to be used when a patient cannot or will not meet alert requirements for medical or personal reasons.</u>** The provider must then select the alert (WHITE BOX) , SELECT A REASON FROM THE drop down and then click the DEACTIVATE button.
  - This will deactivate the alert and it will no longer show on the summary or prescription pad pages.
  - You can Reactivate and remove the reason at any time if you wish by clicking SELECT box besides the Alert you wish to reactivate and clicking the REACTIVATE button

- **Alert Fulfillment**
  - Alert Fulfillment should only be used when the patient has completed the procedure/drug that the alert is calling for, such as a Flu Vaccine, that would not show up in the system through a data feed into the system, such as claims. For example, if the patient got a Flu Vaccine from a local drug store and paid for it themselves.



  - ***To Fulfill an Alert, click the Message Link for that Alert***
    - The Message Link will pop up the description of why the Alert was triggered. It will include the procedure codes or drugs that may complete an alert such as the procedure code(s) for Flu Vaccine. Clicking on this Hyperlink will take you to the **Personal History—Self reported screen** and pull up the selected procedure or drug. **At the moment Lab Alerts can be fulfilled by visiting the Lab screen and updating labs values that meet the Alert goals and prevent the alert from triggering , but only if the patient <u>does in fact</u> have those lab results.**



  - The provider can then enter the date of the procedure or drug and save it to the system. The next time the patient is looked up in the system; the alert should be removed from the screen if all the procedures or drugs that were missing have been added. The system will trigger the alert again when the Clinical Rules determine it necessary based on their online history.

ADD A PATIENT USING DEMOGRAPHICS PAGE

1. Search for your patient using Medicaid ID only (first 12 digits) **OR** SSN only **OR** First & Last Name (initial is optional) & DOB
2. If no match found, the system will display an Add icon to add the patient record to the system.
3. Press button next to Search Results & the Add Demographics Page displays for the user to enter all known information about the patient.

Patient Demographics

Demographics Required data is :

Patient Name	SSN and/or Medicaid ID
Birth date	Patient Address
Gender	

REQUIRED TO enter Patient Name, Birth Date and Gender in the Demographics section AND enter ID Values to allow for later search and retrieval of the Patient Record added.

ID Values—Must add SSN or Medicaid ID—Required

- **Adding a new ID**
  1. Click on add button
  2. Click on down arrow to select the type of ID. (Driver Licence)
  3. Enter in appropriate values.
  4. Click to add the ID Value.
  5. If finished entering all changes, refer to the Save Record instructions.

You must Patient Contact information.

Patient Contact—Required

- **Add New Patient Contact Info**

1. Click on Add Button.
2. Enter in appropriate values.
3. Click to save Contact Info.
4. If finished entering all changes, refer to the Save Record instructions.

Other Fields—Not Required

4. Entry of all other fields on the Demographics add screen are optional. Please enter in any additional information.

Phone numbers— Optional

- **Adding a new "Phone Numbers"**

1. Click on add button
2. Click down arrow to select the desired value to add or change. (Email Address)
3. Enter in appropriate value.
4. Click to add the ID Value.
5. If finished entering all changes, refer to the Save Record instructions.

Emergency Contact Info– Optional

- **Add New Patient Contact Info**

1. Click on Add Button.
2. Enter in appropriate values.
3. Click to save Contact Info.
4. If finished entering all changes, refer to the Save Record instructions.

Save Record

You must select the Save Button using either the button on top or bottom of the screen. This saves all changes made to the main part of the screen. You must save the individual changes to the phone, contact sections by clicking the check mark individually within those areas.

Changing Data

1. Within section, you may click on to change any data.
2. After changing, click on to save the changes.
3. If finished entering all changes, refer to the Save Record Instructions.

Delete Record

- Records cannot be deleted.

EDIT DEMOGRAPHICS

Edit An Existing Patient's Record

NOTE: You will need to click on the SAVE button on the TOP or BOTTOM of the screen even if you click on save in other parts of the screen.

1. Click on  to display EDIT page.
2. Demographics Edit Page displayed. The instructions of each section is below:

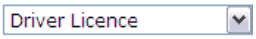
Main Section

NOTE: You may not change data that is a grey color or the row does not have the Edit icon next to it.

1. Enter desired changes.
2. If finished entering all changes, refer to the **Save Record.**

ID Values

- **Adding a new ID**

1. Click on 

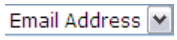
down arrow to select ID.
2. Enter in appropriate value.
3. Click to  add the ID Value.

If finished entering all changes, refer to Save Record.

- **Edit an ID Entered**

1. Click  button on row requiring changes.
2. Enter in appropriate value.
3. Click to  save the ID Value.
4. If finished entering all changes, refer to Save Record .

Phone numbers & E-mail

- **Adding a** 

new "Phone Numbers"

1. Click on down arrow to select the desired type of contact value to **add.**
2. Enter in appropriate value.
3. Click  to add the contact value.
4. If finished entering all changes, refer to Save Record.

- **Edit a "Phone Number"**

1. Click  button on row requiring changes.
2. Enter in appropriate value.
3. Click to  save the contact value.
4. If finished entering all changes, refer to Save Record.

Patient Address Info

- **Add New Patient Address Information**

1. Click on  Add Button.
2. Select Address Type and enter in appropriate values.
3. Click  to save Contact Info.
4. If finished entering all changes, refer to Save Record .

- **Edit Patient Contact Info**

1. Click on  Edit Button.
2. Enter in appropriate values.
3. Click  to save Contact Info.
4. If finished entering all changes, refer to Save Record.

Emergency Contact Info

- **Add New Patient Contact Info**

1. Click on Add  Button.
2. Select Contact Type and enter in appropriate values.
3. Click to  save Contact Info.
4. If finished entering all changes, refer to Save Record.

- **Edit Patient Contact Info**

1. Click on  Edit Button.
2. Enter in appropriate values.
3. Click  to save Contact Info.
4. If finished entering all changes, refer to Save Record.

Save Record 

You must select the Save Button using either the button on top or bottom of the screen. This saves all changes made to the screen.

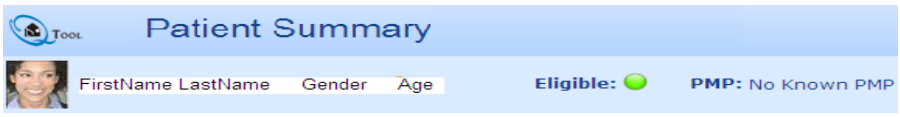
Delete Record

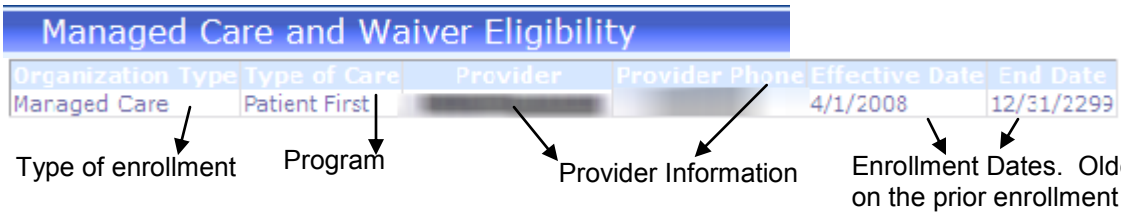
- Patient Records cannot be deleted.

ELIGIBILITY

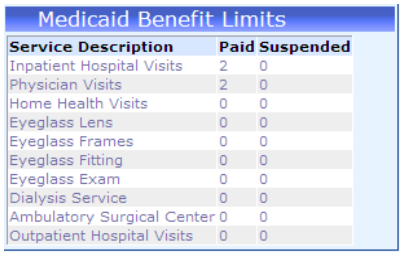
Patient Header Changes

- The patient will display a green circle on the main patient bar if they have active Medicaid eligibility and red if they do not
- The patient PMP will also display on the main patient name bar if they have active managed care for the date the record was pulled.

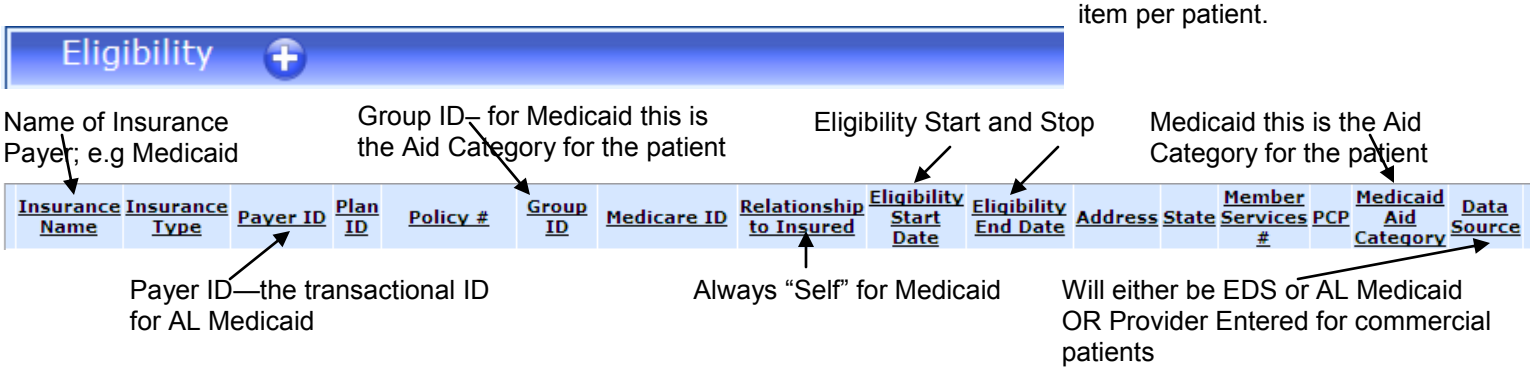




This area will reflect known lock-in or lock-out information for a patient from Medicaid. It will include the name and NPI of the provider they



For the current year-to-date, identifies the number of benefits used for the item as reflected in the Medicaid claims processing system. Please refer to the Medicaid Provider Manual for the max number of benefits allowed per service item per patient.



ADD/EDIT ELIGIBILITY

Add Record

1. Click to Add New Eligibility display fields. You are required to enter the following:
   - Insurance Name
   - Policy ID
   - Relationship
   - Start Date
   - Other fields are optional.
2. Click to save the changes.

Edit Record (Cannot change Medicaid Eligibility)

1. After clicking on the button on the desired row, a screen displays and you are able to all fields.
2. Click on the to save the changes.

Delete Record

NOTE: May only delete provider-entered records

1. Clicking on the button on the desired row for deletion, screen displays with row’s data.
2. Click on button to delete the record.

KNOWN ALLERGY HISTORY

Add Record

1. Click the  button.
2. Provider — Select Physician or Nurse that is entering in the allergy. (This list comes from the Staff data for the location.)
3. Select Allergy Clinical Status (active, unconfirmed, erroneous, or inactive).
4. Select Allergy Type (Animal, Drug, Environmental, Food, Pollen, Other).
5. Enter in the Approximate Allergy Identification Date.
6. Select the Severity (Mild, Moderate, Severe, or Unknown).
7. Select the **PRIMARY** reaction for the allergy.
8. Select the Allergy Description (ie. Peanuts, Mold).
9. **Optional:** Enter in a note related to the Allergy.
10. Click on the 

to save the changes.

Edit Record

- *NOTE: You are only allowed to change the Clinical Status and add a new note from the original record. The original status is retained and displayed with strikethrough text along with the new clinical status record.*

1. Click the  button on the record to edit the allergy.
2. Change the Status to the appropriate category.
3. ***Optional:*** Add a new Note.
4. Click on the 

to save the changes.

Delete Record

- Records cannot be deleted to maintain record integrity in a shared environment.
- ***If the record is completely wrong, then change the clinical status on the incorrect record to erroneous and add a note.***

DIAGNOSIS HISTORY

- Provides two **read-on**ly views of the patient's diagnosis.
- *Self-reported diagnosis or BCBS data will display with no related claim detail information*

1. **Diagnosis History by Major Diagnostic Group Tab**
   - The data is displayed alphabetically by Major Diagnostic Groups.
   - Claims for diagnoses within that grouping are listed.
2. **Diagnosis List Tab**
   - ***This is a list of all the diagnosis codes a user has in their online record (claims and provider entered) grouped by diagnosis code. The dates of service for the diagnosis are grouped below .***
   - The Diagnosis code and Description displays and the detail for that diagnosis code such as date of service and provider are displayed.
   - The data is organized as follows:
     - First Level: Diagnosis Codes and diagnosis description and sorted alphabetically by Diagnosis Description.
     - Second Level: Date of Service and Provider, and sorted current to oldest.

DRUG PA (PRIOR AUTHORIZATIONS)

- The system receives a data feed from Alabama's Prior Authorization Vendor and updates each patient's history with the information received. The screen displays PA history for the patient including approvals and denials.

IN/OUT PAT & ER

- Screen displays the applicable "hospital-related" services together in one view from:
  - Hospital claims based on the admission dates from data received in Payer claims and additional services found from provider claims equal to the admission dates.
  - System gathered data is also displayed to show the full picture of care during the admission.
- The system will de-duplicate the Diagnosis codes reported from the various claims for the patient for that period. All procedures reported for the timeframe will be displayed.

LAB HISTORY—ADD AND EDIT

Incomplete Lab History View

- The Incomplete Lab History view lists out all labs that are not marked as **Finalized**
- The following filters make it easy for you to find the Lab needed.

Finalized Lab History View

- The Finalized Lab history lists out all Labs that the provider has marked as **Finalized**
- The following filters allows you to find easily find specific labels.

Add Lab Record

1. Click button to start documenting a lab and its results.
2. Click to search for Lab Test.
3. Type in a Lab name or partial name like "Lipid" for Lipid Panel or "Metabolic" for Complete Metabolic Panel. If lab is misspelled or not found during the search, delete text from and enter in Procedure new text and click to begin another search.
4. The system will then pop up a list of possible matching values. Select one from the list or Cancel to clear your search and start over with a new search.
5. Click Select to pick the desired Lab.
6. You are required to select the Provider who requested the lab from the drop down list.
7. Make sure the Time and Date for the lab is correct.
8. Click to **add the clinical components of the lab panel or single lab result and save it to the system.**

If lab results are available, execute **Entry of Lab Results** instructions at this time.

If you do not have results yet, execute the following:

1. Scroll the screen down to display the **Order Status** field.
2. Select the appropriate Order Status from the drop down box at the bottom of the screen that best describes the current lab order status..
3. Click
4. A reminder to check the Order status appears. If the valid order status is selected, click the OK button in the pop up. If not, press Cancel & change. Press to save change.
5. When results are available, execute **Entry of Lab Results**.

Entry of Lab Results

1. Location the appropriate Lab on the **Incomplete** Lab History View. Labs are grouped by Date and then Lab Panel name.
2. Click button on the Lab components to Edit the results for the entire lab.
3. For any of the associated results, scroll screen to display Results grid. You are allowed to change date of service, results value, and abnormal flag. You may add notes.
4. Select the appropriate Order Status.
5. Click to Save Lab edit.
6. A reminder to check the Order Status appears. If the valid order status is selected, press OK & lab edit screen is closed. If invalid order status, press OK & change.
7. Press to save change.

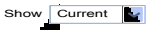
- Until results are complete, the lab results may be edited.

Finalizing Lab Results

- If all result values are added and validated, set Order Status to *"Final results; results stored and verified. Can only be changed with a corrected result."* **Once Order status is set to Final, no user is allowed to edit lab results.**
- Click to exit lab edit.

MEDICATION HISTORY

The medication history screen displays medications from claims data or E-prescribed and identified by a 'Claim', ERx, or "BOTH". Data will be labeled BOTH if a claim and a prescription can be matched up.

- To display current (past 100 days) prescriptions, select Current from the drop-down. 

- To display patient's full medication history, select All option from the drop down. 

- Screen also displays medications grouped by Therapeutic Drug Class and Generic Sequence Number (GSN.) and uses the Current and All options.
- Heading that are underlined can be used to sort the data in ascending or descending order.

MEDICATION HISTORY—ADD/EDIT SELF-PRESCRIBED MEDICATIONS

Add Record

1. Medication History Screen– Self Reported Tab 

2. Click the  button.
3. Click the  button to Look Up a Drug.
4. Type in a drug name or partial name like "Aspr" for Asprin.
5. Click the  to find the drug.
6. Click Select to pick the drug from the results found.
7. Add Frequency (daily, often, occasionally).
8. Add Start and End date (End date is optional). Future Dates are allowed.
9. Select if the drug is physician sample, over the counter, or other.
10. Click on the  to save the changes.

Edit Record

NOTE: Existing record is overwritten.

1. Click the  button on the record to edit .
2. Change Details.

Click on the  to save the changes.

Delete Record

1. Click the  button on the record.
2. Record is displayed.
3. Click on  button to delete the record.

OFFICE VISIT/ER DATA

Office Visits /ER Section include procedures and diagnosis are associated with these codes.

- 99281-99285 Emergency Dept. Services
- 99201-99205 New Patient
- 99211-99215 Established Patient
- 99241-99245 New or Established Patient

PERSONAL HISTORY—SELF REPORTED PROCEDURES (CPT CODES)

Add Record

1. Click  the button.
2. Click  the to search for the Medical Procedure (CPTs/ HCPCS).
3. Type in procedure name or partial name like “hyster” for Hysterectomy.
4. Click Select to pick the Medical procedure.
5. Enter in the year, which is required.
6. Click on the  to save the changes.

Edit Record

1. After clicking on the  button on the row that contains the incorrect data, you are presented with the screen that has the values that were entered.
2. You are able to change the year and procedure and add notes.
2. Click on the  to save the changes.

Delete Record

1. After clicking on the  button on the desired row for deletion, you are represented with the row’s details. This is displayed to ensure that you want to delete the row.
2. Click on the  button to delete the record.

PERSONAL HISTORY—SELF REPORTED CONDITIONS (ICD9) CODES)

Add Record

1. Click the  button.
2. Click the  to search for the desired condition to report (ICD-9s).
3. Type in condition name or partial name like “Diabetes” for Diabetes or “hyper” for Hypertension.
4. Click Select to select the condition from the results list
5. Enter in the approximate onset year (required).
6. Click on the  to save the changes.

Edit Record

1. After clicking on the  button on the row that contains the incorrect data, you are presented with the screen that has the values that were entered. You are able to change the year and condition and add notes.
2. Click on the  to save the changes.

Delete Record

1. After clicking on the  button on the desired row for deletion, you are represented with the row’s details. This is displayed to ensure that you want to delete the row.
2. Click on  button to delete the record.

PERSONAL HISTORY—SOCIAL HISTORY - PERSONAL STATS

Add Record

1. Click on Update the button and a new screen appears.
2. Edit screen displays with the following fields. All fields are optional.
   - **Occupation:** Select from a Department of Labor set of occupation types.
   - **Marital Status:** select from a standard list.
   - **Religion:** select from a list of religions.
   - **Education Level:** select from a list of education levels.
3. Click on the  to save the changes and return back to the Personal History screen.

Edit Record

1. Click on the Update button
2. Edit screen displays with existing data. You are allowed to change any of the following fields.
   - **Occupation:** Select from a Department of Labor set of occupation types.
   - **Marital Status:** select from a standard list.
   - **Religion:** select from a list of religions.
   - **Education Level:** select from a list of education levels.
3. Click on the  to save the changes and return back to the Personal History screen.

Delete Record

- Records cannot be deleted.

PERSONAL HISTORY—SOCIAL HISTORY—SUBSTANCE USED

Add Record

NOTE: You are able to enter in more than 1 substance without leaving the screen.

1. Click on the Add Substance History button and a new screen displays and you are:
   - required to select a substances type of tobacco, alcohol, or other.
2. Once a substance type is selected, you are required to enter data in the following fields:
   - Substance field, a selection of values based on the Substance
   - Quantity
   - Frequency
   - All other fields are optional.
3. Click on the  button to save the changes, which clears the substance fields and will allow you to enter in another substance.
4. Repeat 1—3 to add more substances.
5. When finished entering in substances, click on the Exit button to indicate you are finished and return back to the Personal History screen.

Edit Record

1. After clicking on the  button on the desired row, a screen displays and you are able to change the following fields:
   - Quantity
   - Frequency
   - Age of Onset
   - # of Years
   - Use Notes field to add more description and details
2. Click on the  to save the changes.

Delete Record

1. Clicking on the  button on the desired row for deletion, screen displays with row's data.
2. Click on  button to delete the record.

PERSONAL HISTORY—SELF REPORTED FAMILY HISTORY

Add Record

1. Click Add Family History screen displays to add information.
2. You are required to enter data in the following fields:
   - **Illness** by
     - Clicking on to display search box.
     - Type in a illness or partial name like “Can” or “anc” for Cancer
     - Click Select to pick the illness.
   - **Relation** by selecting from a list of family relation types
   - All other fields are optional.
3. Click to save the changes.

Edit Record

1. After clicking on the button on the desired row, a screen displays and you are able to change the following fields:
   - Date of Onset
   - Date Resolved
   - Date of Birth
   - Date of Death
   - Cause of Death
   - Add a Note
2. Click on the to save the changes.

Delete Record

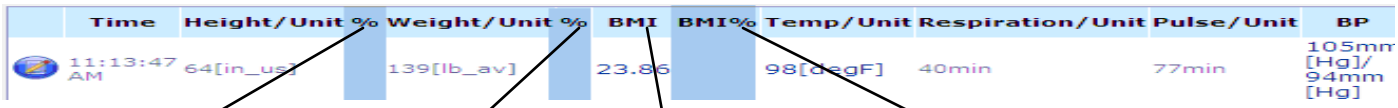
1. Clicking on the button on the desired row for deletion, screen displays with row’s data.
2. Click on button to delete the record.

PROCEDURE HISTORY

- Provides two **read-only** views of the patient's procedures.
- *Self-reported procedures or BCBS data will display with no related claim detail information.*

1. **Procedures by Major Diagnostic Group Tab**
   - The data is displayed alphabetically by Major Diagnostic Groups.
   - Procedures are categorized within each Major Diagnostic Groups. .
2. **Procedure List Tab**
   - ***This is a list of all the procedure codes a user has in their online record (claims and provider-entered) grouped by procedure code. The dates of service for the procedure are grouped below .***
   - The Procedure code and Description displays and the detail for that procedure code such as date of service, place of service, and provider are displayed.
   - The data is displayed as follows:
     - First Level: Procedure Code and Procedure Description and sorted alphabetically by Procedure Description.
     - Second Level: Date of Service, Place of Service, and Provider, and sorted current to oldest.

VITAL SIGNS



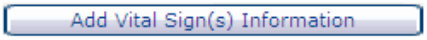
Height Growth % - system auto-calculates CDC Growth % for ages 2-20 when Height is entered based on Age and Height.

Weight Growth % - system auto-calculates CDC Growth % for ages 2-20 when Weight is entered based on Age and Weight.

BMI system auto-calculates for all ages when height and weight is entered based on Gender, Age and Weight

BMI % system auto-calculates CDC BMI % for ages 2-20 based on age, height, weight and gender.

Add Record

1. Click the 

button
2. Enter the Provider, Date, Vital, the Unit and the Method (if applicable)
3. Click on the  to save the changes.

Edit Record

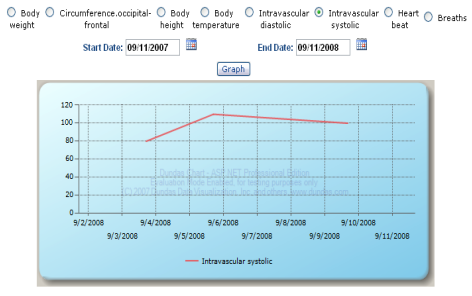
1. Click the  button on the record to edit .
2. The edited record is then displayed with strike-through text to retain the initial data for reference
3. Strike-through records are ignored when vitals are graphed
4. Click on the  to save the changes.

Delete Record

- Records cannot be deleted.

Graphing Data

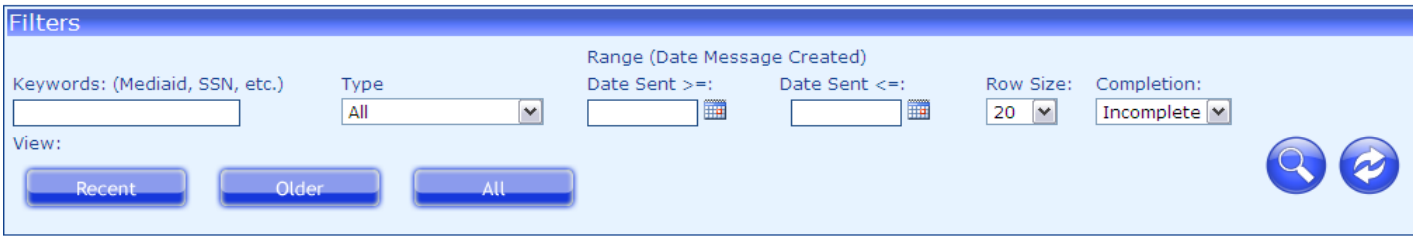
1. Select A Vital To Graph by clicking the Circle
2. Enter a Date Range to Graph
3. Click the Graph Button



MESSAGE CENTER

- The Message Center provides a central location to find Medicaid announcements, Drug PA, e-Prescribing messages Users may use the Message Center as a "To-Do" list or task list. A yellow icon indicates the task is incomplete. A blue icon indicates a completed task.
  - Announcements are messages from Medicaid. All users may read this message.
  - PA
  - E-Rx

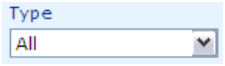
MESSAGE CENTER—FILTERS



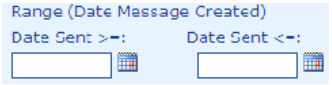
MESSAGE CENTER—FINDING YOUR MESSAGES—USING FILTERS TO FIND

Use any combination of the available filters.

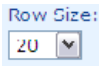
Enter in full words or fuzzy search. Medicaid ID, SSN, etc



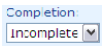
Select Announcement, ePrescribe, or Prior Authorizations from dropdown



Enter in a date range



Default is 20 rows.



Select Incomplete, Complete, or All from dropdown.

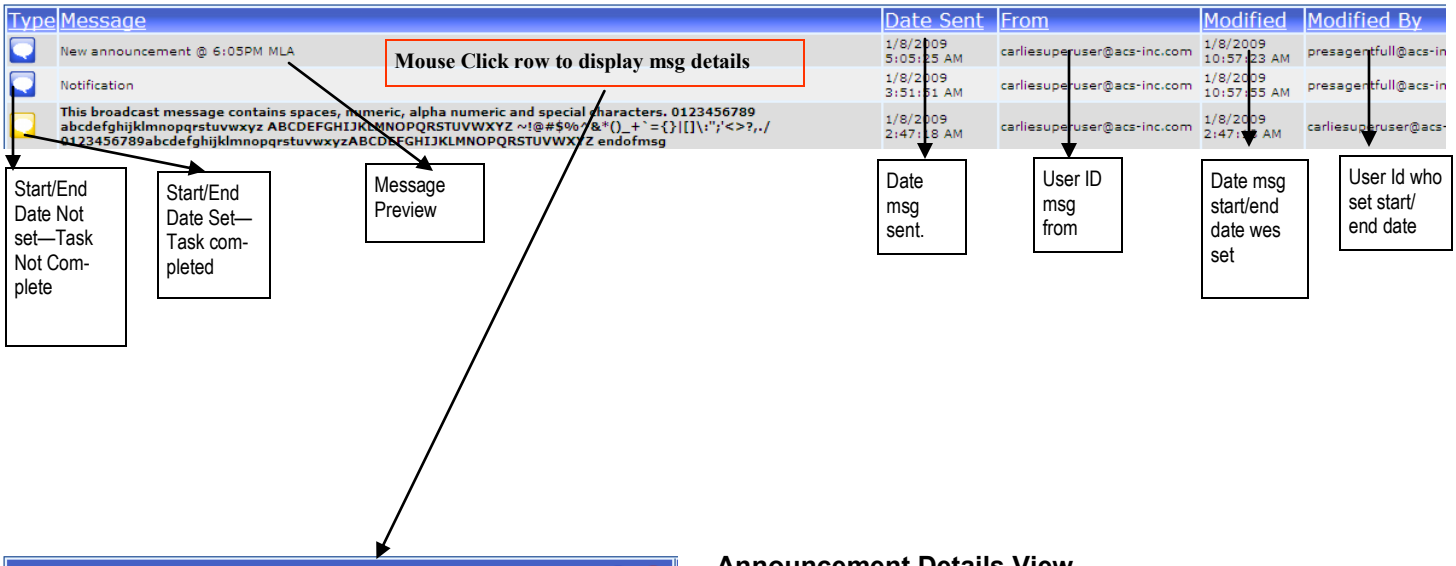
Execute filter by pressing the 

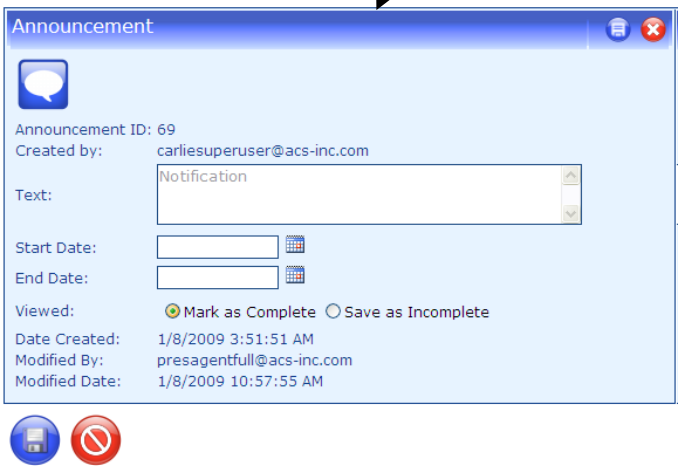
Clear filter by pressing the 

displays messages with a sent date less than the last 15 days from the current date.

displays messages sent date that is greater than 15 days from the current date.

displays all message regardless of date sent.





Announcement Details View

Announcement ID: System generated number

Created by: User id of person who wrote and sent the message

Text: Displays the message text that creator typed.

Start Date: Enter in a date to communicate to staff a start date for this message. It is not required to fill in.

End Date: Enter in a date to communicate to staff an end date for this message. This could identify when the message or rather the "To-Do"
is completed. It is not required to fill in.

Viewed: This mechanism marks the message status. On initial reading, the system sets to Mark as Complete. If the message is completed, then press the button. Select Save as Incomplete to have the message remain in the incomplete status. Press the button.

Date Created: Date the message was sent

Modified By: User id of person who set the start and/or end date

Modified Date: Date that the start and/or end was set.

: Bottom and Top—press to save modifications to the either start date, end date, or Viewed status.

Or press either one if do not want to save modification to start date, end date, or Viewed Status.

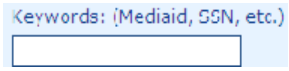
MESSAGE CENTER—FINDING YOUR PATIENT PRIOR AUTHORIZATIONS

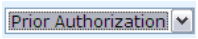
The Provider Message Center will also display Prior Authorization messages returned for any provider whose license number is on file on their Provider Staff page in the system.

Searching for Patient's PA

Access PAs using Filters or selecting PA Icon 

then:

- Enter Patient's Name, SSN, or Medicaid number in the Keyword field. 

- Select Prior Authorizations 

- Execute filter by pressing 

Prior Authorizations—Marking completed

1. If all pertinent staff has read the message

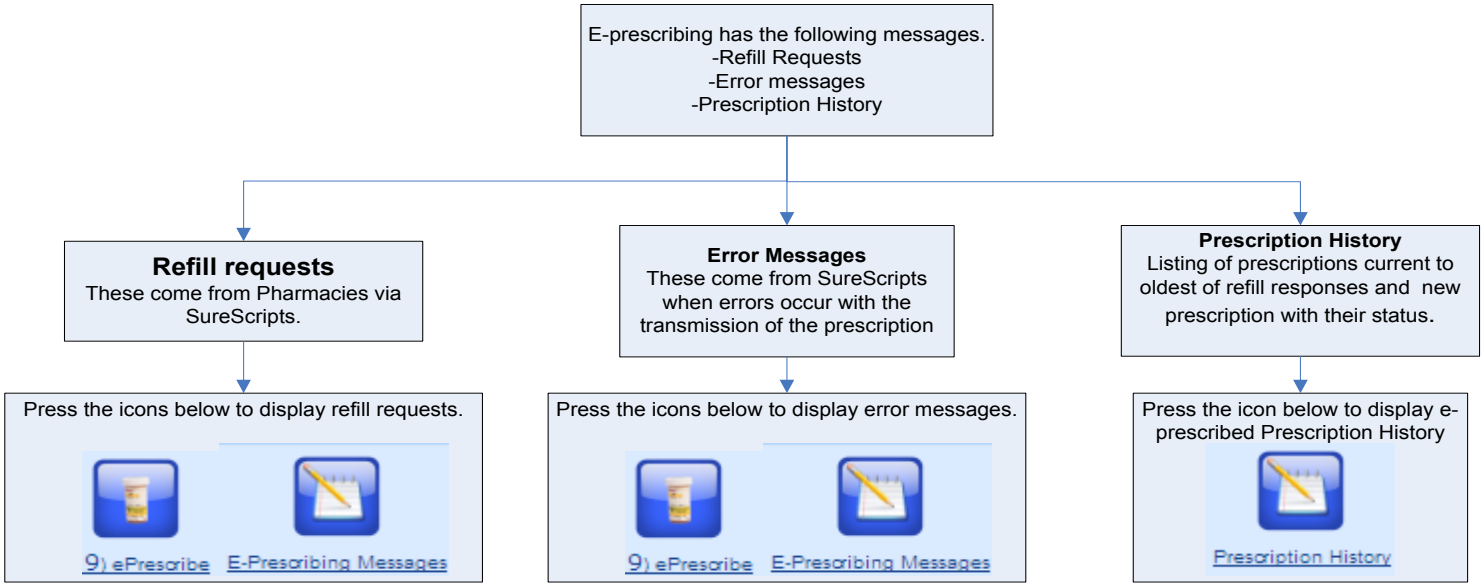
a. Select Mark as Complete

b. **Select**  **Save**

To cancel change select either  or 

MESSAGE CENTER— FINDING YOUR E-PRESCRIBING MESSAGES

This diagram shows users where to find incoming Refill Messages, E-Prescribing Error Messages, and their Location's Prescription History messages for review and response. Refill Messages are the only messages that require a provider response.



PRESCRIBER REFERENCE SHEET

CREATE A PRESCRIPTION—OVERVIEW

1. Patient must be selected.
2. To display the Prescription Pad, select E-Prescribe or Message Center (Top right of screen) → Prescription Pad (Message Center - Icon)
3. Check if prescriber is correct. If not then select appropriate prescriber.
   - Select a Template (page 3)
     OR
   - Search Drug
     - Click the Search button to search for a drug.
     - Type in full name of drug or fuzzy search.
     - Press Search.
     - When results appear, click on to select drug, which will appear in the Drug field on the prescription pad.
4. Enter in quantity, format if not filled in by drug selected,
5. Enter in days supply, refills, and SIG,
6. Confirm if prescription is Dispense as Written or Substitution Permitted and appropriate box is selected.
7. Select a Pharmacy
   - Click Pharmacy the Search button.
   - Type in full name of pharmacy or fuzzy search
   - Select appropriate state and City
   - Click on desired button options to display pharmacy results
   - When results appear, click on to select the pharmacy, which will appear in the Pharmacy field on the prescription pad.
8. **You are now ready to:**

Send — You are ready to fax or E-RX

Save — You are not Ready to Send; or only have the appropriate roles to Save a prescription in Draft for Prescriber Review

Print — You want to print the prescription for the patient or must print the prescription be cause it's a controlled substance.

9. **Prescription Warning**

You may/may not receive a formulary, drug interaction, duplicate therapy or Dose level warning at this time, requiring you to acknowledge (hit OK) to proceed with send or print.

Sending A Prescription Send

E-Prescribing

- If the pharmacy selected is on the SureScripts Electronic Network *(under the Surescripts Pharmacy Selection),* you may press **SEND**, which transmits the prescription to the selected pharmacy.
- The prescription pads continues to display.
- All prescriptions are displayed in Prescription History**.** If transmission errors occur, the system will post a message in green text on top left of the screen and the provider may choose to print or fax the transmission.

Faxing a Prescription

- If the pharmacy selected is a not on the Electronic Network *under Manual Pharmacy Selection),* you may press **SEND**, which transmits the prescription to the pharmacy via FAX.
- Fax errors will appear at top of screen during the send.

Saved Prescriptions Save

Saves the prescription for retrieval at a later time. Displays in the Prescription history with Open Status.

To Retrieve Saved Prescriptions

- The **Prescriber or Prescriber Agent—Full** accesses saved prescriptions by selecting within the Message Center. Prescription History
- Find the desired patient and record and click to display patient's prescription in the Prescription Pad. You are now able to make changes and select print, save, or send.

Print

Printing A Prescription

- To print new or existing prescriptions, press the Print Button on the Prescription Pad and the Prescription Pad Report Viewer is displayed.
- Available formats:
- Prescription creates the Printed Prescription format, which includes the verbiage "Printed Prescription."
- Reminder creates the Prescription Reminder, which include verbiage, "Prescription Pick up Reminder".
- Click on
- Click OK on Print dialog box to send to the Printer.

Office Staff Reference Sheet

MESSAGE CENTER—E-PRESCRIBING—COMPLETING REFILL MESSAGES

Valid actions are Approve, Deny, and Deny with new prescription to follow.

Approve Refill Request

- Modify Refill field with the appropriate quantity
- Press the Approve Button
- Enter a message in Approval/Denial Message box
- Press the send button
- Prescription pad is displayed. A message indicates if the approval was successfully transmitted to Sure-Scripts.

Deny Refill Request

- Press the Deny button
- Message on screen will indicate the status of using SureScripts to send the Denial response to the pharmacy on the request.

Deny with New Prescription to Follow

- Press the Deny /w New RX
- Enter a message in Approval/Denial Message box
- Press the send button
- Prescription pad is displayed with the denied prescription details. A message indicates if deny was successfully transmitted to SureScripts.
- If patient was not searched, then search for the patient and create a new prescription for the new drug.
- If patient was searched, then select the Prescription Pad and enter in new prescription details.

Done

- When selected, closes refill request screen and displays the Prescription Message List.

Delete

- Deletes the message. Make sure you really want to do this. There is no confirmation.

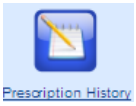
TAMPER PROOF PRESCRIPTIONS

There is no need for printed prescriptions to be on tamper-proof paper. The following items are presented on the printed prescription that adhere to the CMS standards.

- **Micro printing—very small font on the document. This is difficult to photocopy and helps to detect forgeries.**
- **Border and Fill (for computer generated prescriptions on paper only) - The prescription print out does this for Quantity, Refill and Days Supply to prevent changes to the prescription.**
- **Complete list of security features on the prescription paper for compliance purposes.**

PRESCRIBER REFERENCE SHEET

PRESCRIPTION HISTORY SCREEN—STATUS DEFINITION



Prescription History Status definition:

- **Open** indicated that prescription is saved
- **Complete** indicates prescription was printed, faxed or sent via the SureScripts e-prescribing network.
- **Denied with New Prescription to Follow** indicates that the refill was denied and prescriber will send a new prescription.
- **Approved** indicates that refill request was approved and sent back to the pharmacy
- **Denied** indicates that the refill request was denied.

PRESCRIPTION DRUG-DRUG-INTERACTION AND DRUG UTILIZATION REVIEW

- The QTool system has a built in, robust module that checks a prescription at the point of prescription 

send or 

print, against the drugs on file within the system's Medication History database for that patient. This includes checking prescriptions that have been sent by the system and have not yet been picked up or for which we do not have proof of fill as well as all drugs in claims or clinical history.
- The Edits that are triggered are based on national standards (First Data Bank) for Drug-Drug Interaction, Duplicate Therapy and recommended Dose levels.
- The system will present the user with the warning and warning level, but will allow the user to continue with the sending of the drug.

E-PRESCRIBING - CREATING/USING PRESCRIPTION TEMPLATES FOR COMMONLY PRESCRIBED PRESCRIPTIONS

Templates

- Templates can be used to store frequently prescribed drugs prescriptions, such as antibiotics, antihistamines, etc. These can be used to pre-populate a prescription pad.
- When selected, it will fill the prescription pad with the associated values and changes can be made to customize the RX to the patient's needs.
- Prescriber and Prescriber—Agents Full and Partial are only able to create these and are available to any Prescriber and Prescriber-Agents Full and Partial.

Selecting a Prescription Pad Template

- Click on 

from Prescription Pad.
- Select the desired Drug Class from the drop-down list.
- Results are displayed in the grid. Click  to select the template. You are returned to the prescription pad with the values filled in according to the template selected.
- To delete a template, press 
  - Any prescriber, prescriber agent may delete.
- To cancel and not use a template, press 

You are returned to the Prescription Pad with no change made.

Adding a Template 

- Click  on to display the Prescription Template Drug Edit page. (Last drug searched is displayed.)
- Press  to display screen to search for a drug.
- Type in full drug name or fuzzy search.
- Press 

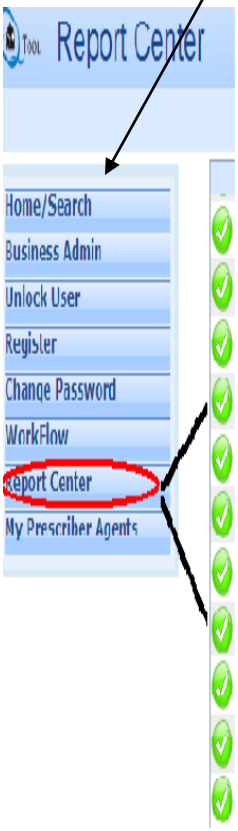
to search.
- When results appear, click  to select drug, which will appear in the Drug field and the associated Format displays on the template edit page as well.
- Fill in the desired quantity, days supply, refills, SIG, and click on Substitution Permitted or Dispense as Written.
- To Save Changes, press 

- To Cancel Template, press 

PROVIDER REPORTS

REPORTS FOR PROVIDERS

- From the Home/Search Page, click on Report Center to access the available reports.
- Click on a menu option when finished viewing the report.



Report Category	Display Name	Explanation
Office	# of E-Prescribing Sent by Provider By Location	Enter in Start and End date and click view Report to see number of e-prescriptions sent by location's providers
Office	# of E-Refills Sent by Provider By Location	Enter in Start and End date and click view Report to see number of refill requests sent by location's providers
Office	# of Patient Searches Execute Grouped by Location	Enter in Start and End date and click view Report to see number of search executed location's providers
Office	E-Prescription Details by Provider by Location	Enter start and end date, select a prescriber or a staff type to see number of e-prescriptions prescribed and sent.
Office	E-Refills Details by Provider by Location	Enter start and end date, select a prescriber or a staff type to see number of refill requests sent.
Office	User List Per Business (Practice)	Enter start and end date to list all users' whose record was created within the start and end date.
Provider Quality	Provider Asthma Panel	Select a provider and a period to obtain a report regarding asthma for the selected provider.
Provider Quality	Provider Diabetic Panel	Select a provider and a period to obtain a report regarding diabetes for the selected provider.
Provider Quality	Provider Quality Trend Asthma	Select a provider and a start and end date to obtain a trend report regarding asthma for the selected provider.
Provider Quality	Provider Quality Trend Diabetes	Select a provider and a start and end date to obtain a trend report regarding diabetes for the selected provider.

HEALTH PROFILE REPORTS

Short Health Profile Report

- Diagnoses (last 30 known diagnosis)
- Allergies, Adverse Reactions, Alerts
- Medications (last 100 days)
- Known Immunizations in the last year
- Last record vital
- Lab Results
- Procedures (last 30 known procedures)

Full Health Profile Report

- All Diagnoses
- Family History—Display family history entered by provider
- Social History—Display social history entered by provider
- Allergies, Adverse Reactions
- Medication (last 100 days)
- Immunizations (all known immunization from claims)
- Vital Signs (all vital signs entered)
- Lab Results (all lab results entered)
- Procedures (all procedures)
- Encounters (provider-entered office visits)

ADMINISTRATIVE REPORTS

REPORTS FOR ADMINISTRATORS

- From the Home/Search Page, click on Report Center to access the available reports.
- Click on the a menu option when finished viewing the report.

Report Category	Display Name	Explanation
Administrative	# of E-Prescribing Sent by Provider By Location	Enter in Start and End date and click view Report to see number of e-prescriptions sent by location's providers
Administrative	# of E-Refills Sent by Provider By Location	Enter in Start and End date and click view Report to see number of refill requests sent by location's providers
Administrative	# of Patient Searches Execute Grouped by Location (all locations)	Enter in Start and End date and click view Report to see number of search executed location's providers
Administrative	# of Patient Searches from EMRs	Enter start and end date, select a prescriber or a staff type to see number of e-prescriptions prescribed and sent.
Administrative	DDI severity 1 Prescribed	Enter in start and end dates, select business, locations or a specific role or user and list DDI Severity 1 that were prescribed during the start and end dates.
Administrative	Training Executed Per Business Per Location	Enter start and end date to list the users' training that occurred between the start and end dates.
Administrative	Users List Per Business (Practice) (All Businesses)	Enter start and end date to list all users for all businesses.
Trend	Medicaid Asthma Quality Trend by County	Select start and end date and the County to obtain a trend report regarding asthma for the providers in the County.
Trend	Medicaid Asthma Quality Trend by Provider	Select start and end date and the County to obtain a trend report regarding asthma for a selected providers.
Trend	Medicaid Diabetes Quality Trend by County	Select start and end date and the County to obtain a trend report regarding diabetes for the providers in the County.
Trend	Medicaid Diabetes Quality Trend by Provider	Select start and end date and the County to obtain a trend report regarding diabetes for the selected provider.